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ABSTRACT

Codependency is a relatively new idea, emerging in the late 1970s within the chemical dependency treatment industry. However, the belief that the wife of the alcoholic is, by definition, disturbed, has been influential in varying degrees since the 1930s. The perennial influence of the codependency hypothesis suggests that it is a social construction which has been influenced by traditional assumptions about gender in our society. Feminist criticisms of codependency theory contend that society demands that women be nurturing, caring, and sensitive to others' needs--the same behaviors viewed in codependency as unhealthy and diseases--and feminists have raised several reproaches related to this view: (1) Systemic family therapy, some feminists declare, treats families as isolated from other social influences and tends to pathologize normative family interactions which have been socially dictated; (2) the Self-Defeating Personality Disorder, which bears diagnostic criteria similar to the Codependent Personality Disorder, implies that women who are battered by their mate are responsible for their own victimization. Recent studies have sought to disassociate codependency with battered women. In an ongoing project, the author of this study will examine codependency definitions, as well as the experiences of codependents, using interviews and other methodologies. (Contains 76 references.) (RJM)

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# CODEPENDENCY:

# Innovation or Status Quo?

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## Abstract

Codependency[1] is usually described as a relatively new idea, emerging in the late 1970s within the chemical dependency treatment industry (e.g., Schaef, 1986; Wegscheider-Cruse, 1984). In fact, the belief that the wife of the alcoholic is, by definition, disturbed (i.e., the Disturbed Personality Hypothesis; Edwards, Harvey, & Whitehead, 1973) has been influential in varying degrees since the 1930s. Despite their lack of empirical foundation, codependency theory recapitulates many of the ideas about the alcoholic's spouse that were developed decades earlier (Bailey, 1961; Edwards, Harvey, & Whitehead, 1973; Gierymski & Williams, 1986; Morgan, 1992). The perennial influence of these ideas, which can also be seen in the Self-Defeating Personality Disorder, suggests that they are fulfilling a societal imperative; feminist analysis reveals its nature. However, when coupled with the values of emancipation found in the treatment of abused women, codependency theory loses much of its pathologizing stigma.


[1] *Codependency* (also known as *co-dependency*, *co-alcoholism*, and *co-addiction*) refers to an emotional, physical, and spiritual disorder commonly identified among the members of dysfunctional families, particularly those affected by substance abuse (e.g., Beattie, 1987; Bradshaw, 1988; Whitfield, 1989).

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## Codependency's Similarity to the Early Literature

### 1. Assumption of Disturbance

#### i) Early Literature:

Much of the early literature, based on case studies in the psychoanalytic tradition, implies that marriage to an alcoholic is sufficient evidence of a character pathology (Boggs, 1944; Margaret Lewis, 1954; Marion Lewis, 1937; Price, 1945; Whalen, 1953).

These authors described a woman riddled with personality conflicts. She was seen as hostile, domineering, dependent (but with a strong "need to be needed"), uncomfortable with her femininity, insecure, resentful, orally fixated, masochistic, distrustful, indecisive, insincere, and punitive.

These personality problems were assumed to predate the marriage to an alcoholic. Because her husband's alcoholism was assumed to meet the wife's neurotic needs, her personality was seen as contributing to both the marriage to an alcoholic (e.g., Forizs, 1953) and to the alcoholism itself (e.g., Bullock & Mudd, 1959; Futterman, 1953; Mitchell, 1959).

Empirical support for this perspective was weak or non-existent (e.g., Ballard, 1959). Nonetheless, this vision had a profound influence:

> The popular digests of these articles, circulated by various news media, have given the public a picture of the male alcoholic as a virtual victim of controlling females, excessively loving wives, or martyr-type mothers (Clifford, 1964, p. 457).

In contrast to this view, sociologist Joan Jackson (1954) suggested that the wife of an alcoholic was an essentially normal personality dealing with an extraordinary stressor. Through the 1960s and 1970s, empirical support was generated for this idea (Corder, Hendricks, & Corder, 1964; Haberman, 1964; Kogan, Fordyce, & Jackson, 1963; Kogan & Jackson, 1963; Kogan & Jackson, 1965; Tarter, 1976).

In 1973, Edwards et al. reviewed the literature, and concluded that Jackson's hypothesis was the more adequate. However, the Disturbed Personality Hypothesis continued to appear in various forms (e.g., Welsh, 1975; Schaffer & Tyler, 1979). Codependency theory continues the tradition.

#### ii) Codependency Literature:

The assumption that those involved with alcoholics are automatically disturbed is common in the codependency literature (e.g., Beattie, 1987; Bradshaw, 1988).

The many symptoms identified with codependency focus nearly exclusively on the personality. Cermak (1984, 1986a,b) has attempted to legitimate codependency as a personality disorder. Wallace (1984) echoed the familiar refrain that the neurotic needs of the codependent are met by marriage to an alcoholic. Codependency is frequently described as affecting one's identity and personal boundaries, suggesting that the most fundamental fabric of the self is damaged (e.g., Beattie, 1987; Cermak, 1986b; Evans, 1987; Schaef, 1986).

Some codependency theorists believe that the codependent's problems predate the involvement with the alcoholic (e.g., Young, 1987). Others believe that the problems are the result of living with an external stressor (e.g., Mendenhall, 1989). However, there is no debate between these positions.

Perhaps this is because there is no functional difference between them. Whether due to personality conflicts or

an external stressor, the codependent is assumed to be permanently disturbed (Mendenhall, 1989), in constant danger of relapse (Gorski & Miller, 1984), and in need of lifelong treatment (Beattie, 1987).

The term "codependency" has been constructed as a psychiatric illness, and invites the stigma associated with other psychiatric illnesses. Beattie (1987) repeatedly refers to codependent behavior as "crazy," with the opposite of "codependent" being "sane."

One major difference sets codependency apart from the Disturbed Personality Hypothesis. The label "wife of an alcoholic" was clearly limited in its applicability. At first, codependency was similarly limited to those in relationships with alcoholics (e.g., Wegscheider-Cruse, 1984). Since then, however, codependency has been described in epidemic proportions. Bradshaw (1988) suggests that every member of a dysfunctional family is codependent, and that 96% of all families are dysfunctional. Schaef (1986) suggests that society supports, and even demands, development of the disease.

## 2. Causing and Maintaining Alcoholism

Proponents of the Disturbed Personality Hypothesis commonly held that the wife of the alcoholic caused or maintained the alcoholism, as it suited her own neurotic needs (e.g., Forizs, 1953; Futterman, 1953).

In codependency literature, a similar idea is seen in the concept of the "enabler," who protects the alcoholic from the consequences of his actions (Mapes, Johnson, & Sandler, 1984; Wegscheider, 1981). The concept of "enabler" is so similar to the concept of "codependent" as to be nearly indistinguishable from it (Whitfield, 1984).

The enabler has been described as not only maintaining the drinking, but contributing to its development (Whitfield, 1984). Miller & Millman (1989) describe the enabler as a "common cause" of alcoholism.

## 3. Emphasis on Women

In the early literature, the emphasis on women is quite blatant. Very little work was done on male spouses of alcoholics, while the phrase *wife of an alcoholic* essentially became the label for a personality disorder.

The emphasis on women in the codependency literature is much more subtle. Most authors use the conventional "him or her" to indicate that codependents can be male or female. However, this apparently non-sexist language obscures the actual gender distribution of alcoholics and codependents.
Alcohol abuse is 2-6 times more prevalent among males (DSM-III-R, 1987). Further, most men married to alcoholics leave, while most women married to alcoholics stay (Gomberg, Nelson, & Hatchett, 1991). Among the spouses of alcoholics, the majority will be women.

Women are also more likely than men to come into contact with the label "codependent." Women are more likely to seek therapy, and therefore, to be diagnosed by an authority. Eighty-five percent of the market for self-help books consists of women (Kaminer, 1990), and most of the members of Al-Anon and similar groups are women (e.g., Cutter & Cutter, 1987). Women are more likely to identify themselves as being Adult Children of Alcoholics (e.g., Hinz, 1990). Without question, the majority of people identified as codependents will be women.

## 4. Gender Role Disturbance

From the time of the earliest articles on the wife of the alcoholic (e.g., Lewis, 1937), she and her husband were viewed as having reversed their gender

roles. The alcoholic was seen as feminine for being out of control, dependent, and an inadequate provider for the family, while the wife was seen as masculine for attempting to control her husband, punishing him, and taking over his responsibilities in the home.

The theme of the weak, inadequate man and the domineering, aggressive woman appeared repeatedly in the literature (e.g., Whalen, 1953; Ballard, 1959). Traditional gender roles were accepted as healthy, and a major goal of intervention with the alcoholic's family was to restore the male to familial control (e.g., Boggs, 1944).

By 1975, the wives were seen as being too masculine AND too feminine. Welsh (1975) conducted an MMPI study of wives of alcoholics. The wives, Welsh said, conform to "a stereotype of being submissive, yielding, weak, self-pitying, soft, hesitant, constricted, dependent, 'bitchy,' fault finding, complaining, and conformist" (1975, p. 52). She also described their behavior as obnoxious and aggressive, alternating with demure femininity used to gain sympathy.

In the codependency literature, this ambivalence about gender roles has continued. Concern with the control over the family by the codependent has persisted (Burnett, 1984). However, both domineering and submissive behaviour can be evidence of codependency (e.g., Beattie, 1987). The feminine roles of caring and nurturing and the masculine roles of power and control have both been described as addictive; Schaef (1986) suggested that unliberated women and unenlightened men are both codependent. Still, the classic codependent continues to be the nurturant caretaker who puts aside her own needs.

## FEMINISM AND CODEPENDENCY

Feminists have been among the most vocal opponents of the theory of codependency. They are concerned that women who are displaying the behaviours of a well-socialized female are prominent contenders for the label (e.g., Krestan & Bepko, 1990; van Wormer, 1989), as they are for other labels of pathology (Franks, 1986; Rorbaugh, 1979). Although society demands that women adhere to the archetype of the woman as nurturing, caring, and sensitive to others' needs, the same pattern of behaviours is censured as unhealthy and diseased (Frank & Golden, 1992; Lawler, 1992). According to codependency theory, the answer to women's problems resides within themselves, not in social action (Webster, 1990), thus depoliticizing their struggles (Brown, 1990; in Lawler, 1992).

However, a number of feminists recognize some value in the construct. For example, recovery from "codependency" can help women to recognize their own needs, deal with some of the conflicting demands placed on them, reduce their isolation, and legitimize their experiences (Asher, 1992; Haaken, 1990; Krestan & Bepko, 1990; Webster, 1990). And the women may be politicized simply by being brought together to share their common experiences (O'Gorman, 1991).

## FEMINIST CRITIQUE OF SYSTEMS THEORY

Feminists have also expressed concern with systemic family therapy, which holds that each member of the family affects all the other members (Bowen, 1974). This formulation has been an important rationale for codependency theory (Bradshaw, 1988; Wegscheider, 1981; Harper & Capdevila, 1990).

By treating the family as isolated from other social influences, systems theorists may fail to see how cultural forces affect the typical "dysfunctional" family, with its overinvolved mother and peripheral father (Goldner, 1985; Taggart, 1985). Roles are assumed to emerge within the family system; therefore, gender is not seen as a determinant (Bograd, 1986). Normative

family interactions which have been socially dictated are pathologized (Bograd, 1987).

Taken to extremes, systems theory can blur the distinction between victim and victimizer (Taggart, 1985). Responsibility for violence may be taken from battering men, as the violence can be seen as only one move in a game in which the wife is a powerful player (McCannell, 1986). Similarly, wives would have to share the responsibility for the drinking of alcoholic husbands (Penfold, 1989).

### Codependency and the Self-Defeating Personality Disorder

When the revision to the DSM-III was underway, feminists vigorously objected to the inclusion of some new diagnostic labels. One of these was the Masochistic Personality Disorder, or as it later came to be known, Self-Defeating Personality Disorder (SDPD) (Franklin, 1987). Because of the ardent protest against the diagnosis, it was relegated to an appendix of the DSM-III-R.

SDPD's diagnostic criteria bear a striking resemblance to Cermak's criteria for the Codependent Personality Disorder (see pp. 11-12). Specifically, both diagnoses describe people who are self-effacing, disinterested in their own needs, extremely sensitive to the people around them, and who respond with guilt, anger, hurt, and manipulation when faced with relationship issues. Both appear to apply more frequently to women than to men. Both diagnoses refer in particular to those who are dependent on relationships which are unlikely to fulfil their needs. Indeed, DSM-III-R lists as an example of SDPD "a woman [who] repeatedly chooses to enter relationships with men who turn out to have Alcohol Dependence and to be emotionally unavailable..." (p. 372), thus describing the quintessential codependent.

Kass, one of the authors of the only empirical study on the Masochistic Personality Disorder which predated its inclusion in DSM-III-R (Kass, Mackinnon, & Spitzer, 1986; in Caplan, 1987b),[1] described another self-defeating archetype: "...the martyrish mother who always arranges to get the short end of the stick and whose manipulative, resentful, long-suffering manner reflects a profound lack of self-esteem" (Science, 1986, p. 328). Again, the parallels between SDPD and codependency are readily apparent.

The feminist response to SDPD was largely concerned with the effects of the label on battered women (Franklin, 1987). Rosewater (1987) and Walker (1987) note that the behavior of the SDPD and of battered women may be quite similar. Because many women are not immediately identified as victims of abuse, they believe that the DSM-III-R's disclaimer (i.e., that people responding to abuse should not be so diagnosed) is useless.

The diagnosis of SDPD has the effect of implying that women are responsible for their own victimization, and that any problematic behaviors in the victim are the CAUSE of her victimization, not the reaction to it (Rosewater, 1987).

Many of the SDPD's critics point out that the diagnostic criteria mimic the behavior demanded by society of women (Walker, 1987; Caplan, 1987a,b). Franks (1986) notes that girls are generally brought up to be dependent and compliant; when they are adults, the expectations suddenly change, and they are expected to be independent and achievement-oriented. When adult women continue with the self-denying behavior which, as children, they were socialized to display, they are labelled as disordered (Caplan, 1987b).

### Codependency and Battered Women

Different philosophies have brought different meaning, and hence, different responses, to the problems

described by the terms *codependent* (or *self-defeater*), and *battered woman*. Although those who use these labels describe the behavior of their clientele in strikingly similar terms, their beliefs about the nature of these problems varies greatly.

The predominant perspective on battered women emphasizes that the battering is in no way her fault, and that any problems she is experiencing are a result of the abuse, not the cause of it (Ieda, 1986). Her complete recovery from these problems will follow the cessation of the victimization, especially if she receives some form of intervention (Walker, 1987).

By contrast, the codependent is seen as having a permanent condition demanding lifelong recovery (Gorski & Miller, 1984; Beattie, 1987), is often described as personality disordered rather than as responding to external realities (Young, 1987), and is viewed as contributing to the alcohol abuse (Murphy, 1984; Miller & Millman, 1989). How can these differences in perspective be resolved when the a woman is battered by an alcoholic husband?

Two works which deal with battering and codependency bear a striking similarity in their approach to the issue. In a brief article on treatment issues with battered wives of alcoholics, Lindquist (1986) describes both codependency and the reaction of battered women as a normal response to a severe external stressor.

The other work, Abused no more (Ackerman & Pickering, 1989), is a more extensive self-help guide for women whose husbands are abusive, alcoholic, or both. Ackerman & Pickering (1989) label abused women as "codependent," but do not describe codependency as a disease, a personality problem, or as a permanent stress reaction. Instead, they describe codependency as a natural reaction to the stress of living in either abusive situation.

Ackerman & Pickering (1989) see both the wife of the alcoholic and the wife of the abuser as victims of male domination. The authors note, "...there is no such thing as a non-abusive alcoholic relationship" (p 87).

Their greater sensitivity to the situation in which these women find themselves can be seen in how they deal with the issue of "enabling:"

> Enabling is a delicate issue. To say that a victim enables is to blame the victim. We do not mean that victims contribute to their own victimization. Enabling does not lead to or cause victimization as much as it allows it to continue once it starts. (Ackerman & Pickering, 1989, p. 107)

Frank and Golden (1992) warn against using the label of *codependent* with battered women, which they defined as a personality disorder. However, when codependency is connected to emancipatory values such as those in the abuse treatment field, it can lose its permanency, its conception as a disease, its construction as a personality disorder, and much of its pathologizing stigma. The response to "codependency" has the potential to empower the woman by offering her control over her own life.

## Conclusions and Future Directions

Codependency is a social construction which is molded by political structures, value systems, and historical context (cf. Gergen, 1985). The theory has been influenced by traditional assumptions about gender in our society. However, those who identify themselves as codependent often experience their recovery as liberating (e.g., Asher, 1992). Codependency theory rides a razor's edge between emancipation and oppression.

In my ongoing dissertation project, the subjective definitions and experiences of codependents will be examined, using semi-structured interviews and Q-methodology (Kitzinger, 1987). Pilot interviews already completed have demonstrated that even members of the same Al-Anon group can have widely divergent ideas about codependency, corroborating an earlier study (Asher & Brissett, 1988).

Codependency is an unusual diagnostic entity. Its adherents and experts typically are not professionals, but those who identify the disease in themselves (Schaef, 1986). Yet codependency has been constructed with much the same form, substance, impact, applicability, and assumed validity of any other personality disorder. Codependency is likely influenced by the same assumptions about human nature and the same value systems as any mainstream diagnosis.

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## CODEPENDENT PERSONALITY DISORDER[2]

1. **Continual investment of self-esteem in the ability to influence/control feelings and behaviour in self and others in the face of obvious adverse consequences**

2. **Assumption of responsibility for meeting other's needs to the exclusion of meeting one's own needs**

3. **Anxiety and boundary distortions in situations of intimacy and separation**

4. **Enmeshment in relationships with personality disordered, drug dependent and impulse disordered individuals**

5. **Exhibits (in any combination of three or more):**

   **-Constriction of emotions with or without dramatic outbursts**
   **-Depression**
   **-Hypervigilance**
   **-Compulsions**
   **-Anxiety**
   **-Excessive reliance on denial**
   **-Substance abuse**
   **-[Exposure to] recurrent physical or sexual abuse**
   **-Stress-related medical illnesses**
   **-A primary relationship with an active substance abuser for at least two years without seeking outside support**

## SELF-DEFEATING PERSONALITY DISORDER[3]

**A.** **A pervasive pattern of self-defeating behavior, beginning by early adulthood and present in a variety of contexts. The person may often avoid or undermine pleasurable experiences, be drawn to situations or relationships in which he or she will suffer, and prevent others from helping him or her, as indicated by at least five of the following:**

**(1)** **chooses people and situations that lead to disappointment, failure, or mistreatment even when better options are clearly available**

**(2)** **rejects or renders ineffective the attempts of others to help him or her**

**(3)** **following positive personal events (e.g., new achievement), responds with depression, guilt, or a behavior that produces pain (e.g., an accident)**

**(4)** **incites angry or rejecting responses from others and then feels hurt, defeated, or humiliated (e.g., makes fun of spouse in public, provoking an angry retort, then feels devastated)**

**(5)** **rejects opportunities for pleasure, or is reluctant to acknowledge enjoying himself or herself (despite having adequate social skills and the capacity for pleasure)**

**(6)** **fails to accomplish tasks crucial to his or her personal objectives despite demonstrated ability to do so, e.g., helps fellow students write papers, but is unable to write his or her own**

**(7)** **is uninterested in or rejects people who consistently treat him or her well, e.g., is unattracted to caring sexual partners**

**(8)** **engages in excessive self-sacrifice that is unsolicited by the intended recipients of the sacrifice**

**B.** **The behaviors of A do not occur exclusively in response to, or in anticipation of, being physically, sexually, or psychologically abused**

**C.** **The behaviors in A do not occur only when the person is depressed**

1.Another si larity is SDPD's lack of adequate empirical support (Caplan, 1987a,b, 199 . Caplan eventually concluded that the warm reception which the Am rican Psychiatric Association gave to the SDPD, despite its extremely weak empirical foundation, could best be explained by the fact that the Association's membership is 86% male (1991).

2.Reprinted from Cermak (1986b, pp. 16-17).

3.Reprinted from DSM-III-R (American Psychiatric Association, 1987, pp. 373-374).